

**TRANSMITTAL AND NOTICE OF APPROVAL OF
STATE PLAN MATERIAL**

FOR: HEALTH CARE FINANCING ADMINISTRATION

**TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:

02-06

**2. STATE
NC**

**3. PROGRAM IDENTIFICATION: TITLE XIX OF THE
SOCIAL SECURITY ACT (MEDICAID)**

4. PROPOSED EFFECTIVE DATE

March 4, 2002

5. TYPE OF PLAN MATERIAL (Check One):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

42 CFR 440.230(d)

7. FEDERAL BUDGET IMPACT:

a. FFY 02 (\$ 2,879,917)

b. FFY 03 (\$ 6,228,500)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 3.1-A.1 Page 14

**9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION
OR ATTACHMENT (If Applicable):**

Attachment 3.1-A.1 Page 14

10. SUBJECT OF AMENDMENT: Prior authorization requirement for certain prescription drugs.

11. GOVERNOR'S REVIEW (Check One):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:

Carmen Hooker Odom

13. TYPED NAME:

Carmen Hooker Odom

14. TITLE:

Secretary

15. DATE SUBMITTED:

MARCH 26, 2002

16. RETURN TO:

**Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001**

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:

March 25, 2002

18. DATE APPROVED:

August 9, 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:

March 4, 2002

20. SIGNATURE OF REGIONAL OFFICIAL:

Rhonda K. Cottrell

21. TYPED NAME:

Rhonda K. Cottrell

**22. TITLE: Associate Regional Administrator
Division of Medicaid**

23. REMARKS:

12.a. Prescribed Drugs

- (1) Limited to legend drugs and insulin. Insulin is the only over the counter drug presently covered. Prior authorization is required for certain high-cost drugs which are subject to over-utilization or abuse.
- (2) For Non MAC drugs a prescription designated by a brand or trade name for which one or more equivalent drugs are available shall be considered to be an order for the drug by its generic name, except when the prescriber personally indicated in writing or in his own handwriting on the prescription order "DISPENSE AS WRITTEN". For MAC drugs the physician must write in his own handwriting on the face of the prescription "brand necessary", "dispense as written", or words of similar meaning.
- (3) Prescription drugs will be limited to six (6) per month per recipient including refills. Additional prescription drugs in excess of the six (6) per recipient per month limit may be authorized by the State agency in emergency situations when the life of the patient would be threatened without such additional services. This limitation does not apply to EPSDT eligible children.
- (4) Drugs for which Medical Assistance reimbursement is available are limited to the following:

Covered outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Act which are prescribed for a medically accepted indication. In addition, prior authorization must be obtained from the Medicaid agency or its authorized agent for any drug on the prior authorization list before Medicaid reimbursement is available. The state provides for response by telephone or other telecommunication device within 24 hours of a request for prior authorization. The state also provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation.